

## NOTICE OF INDEPENDENT REVIEW DECISION

October 31, 2002

RE: MDR Tracking #: M2-02-1152-01  
IRO Certificate #: 4326

\_\_\_ has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The Texas Workers' Compensation Commission (TWCC) has assigned the above referenced case to for independent review in accordance with TWCC Rule §133.308 which allows for medical dispute resolution by an IRO.

\_\_\_ has performed an independent review of the proposed care to determine if the adverse determination was appropriate. In performing this review, relevant medical records, any documents utilized by the parties referenced above in making the adverse determination, and any documentation and written information submitted in support of the appeal was reviewed.

The independent review was performed by a \_\_\_ physician reviewer who is board certified in orthopedic surgery which is the same specialty as the treating physician. The \_\_\_ physician reviewer has signed a certification statement stating that no known conflicts of interest exist between him or her and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for a determination prior to the referral to \_\_\_ for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to this case.

### Clinical History

This 54 year old female sustained a work related back injury on \_\_\_ while moving clothes racks. Subsequent to the injury the patient underwent several lumbar spine procedures including chemonucleolysis on 04/11/94, hemilaminectomy and disectomy on 08/09/94, decompressive laminectomy and fusion on 05/08/96, hardware removal and exploration of fusion on 09/10/97 and anterior disectomy and fusion on 05/19/99. Conservative treatment has included medications, physical therapy, work conditioning and injections. She continues to complain of severe right-sided leg pain. The treating physician is recommending a lumbar MRI.

### Requested Service(s)

Lumbar MRI

### Decision

It has been determined that a lumbar MRI is not medically necessary.

### Rationale/Basis for Decision

This patient is now more than 10 years post injury. She has undergone several imaging studies and at least two spinal surgeries. An MRI of the lumbar spine was performed on 03/06/01 and correlated with a previous study on 01/16/98. The MRI scan on 03/06/01 did not reveal findings suggestive of compressive neuropathy at any level. A repeat MRI is unlikely to provide any additional information. Therefore, a lumbar MRI is not medically necessary.

This decision by the IRO is deemed to be a TWCC decision and order.

### **YOUR RIGHT TO REQUEST A HEARING**

Either party to this medical dispute may disagree with all or part of the decision and has a right to request a hearing.

**If disputing a spinal surgery prospective decision** a request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings within **10** (10) days of your receipt of this decision (20 Tex. Admin. Code 142.5 (c)).

**If disputing other prospective medical necessity (preauthorization ) decisions** a request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision (28 Tex. Admin Code 148.3).

This Decision is deemed received by you 5 (five) days after it was mailed (28 Tex. Admin Code 102.4(h) or 102.5(d)). A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Workers' Compensation Commission, P.O. Box 40669, Austin, Texas, 78704-0012. **A copy of this decision should be attached to the request.**

The party appealing the decision shall deliver a copy of its written request for a hearing to all other parties involved in the dispute (Commission Rule 133.308 (t)(2)).

Sincerely,